DELAWARE HEALTH AND SOCIAL SERVICES
Division of Long Term Care Residents Protection

DHSS - DLTCRP
3 Mill Road, Suite 308
Wilmington, Delaware 19806
(302) 577-6661

STATE SURVEY REPORT

NAME OF FACILITY: Shipley Manor Assisted Living

DATE SURVEY COMPLETED: January 19, 2012

SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED
	An unannounced annual survey was conducted at this facility beginning January 17, 2012 and ending January 19, 2012. The facility census on the entrance day of the survey was 13 residents. The survey sample was composed of 2 residents. The survey process included observations, interviews and review of resident clinical records, facility documents and facility policies and procedures.	This plan of correction is prepared and executed because it is required by the provisions of the state and not because Shipley Manor agrees with the allegation and citations(s) listed on the statement of deficiencies. Shipley Manor maintains that the alleged deficiencies do not, individually and collectively, jeopardize the health and safety of the residents, nor are they of such character as to limit our capacity to render adequate care as prescribed by regulation. This plan of correction shall serve as Shipley Manor's credible allegation of compliance as of the last plan of correction completion date. By submitting this plan of correction, Shipley Manor does not admit to the accuracy of the deficiencies. This plan of correction is not meant to establish any standard of care, contract, obligation, or position, and Shipley Manor reserves all rights to raise all possible contentions and defense in any civil or criminal claim, action, or proceeding.
3225.0	**Assisted Living Facilities**	
3225.8.0	**Medication Management**	
3225.8.10	**Each assisted living facility shall complete an annual AWSAM report on the form provided by the Board of Nursing. The report must be submitted pursuant to the Delaware Nurse Practice Act, 24 Del.C. Ch. 19.** **This requirement is not met as evidenced by:** Based on review of facility documents and staff interview it was determined that the facility failed to ensure that an annual AWSAM report was completed and submitted to the Board of Nursing by August 1, 2011 for seven AWSAM staff members (A1, A2, A3, A4, A5, A6 and A7) out of seven AWSAM staff members sampled. Findings include: Review of the annual AWSAM report dated 1/17/2012 and submitted to the Board of Nursing by the facility revealed seven out of seven AWSAM staff members completed certification/recertification prior to August 1, 2011:	1. No residents were affected. 2. No other residents have the potential to be affected. 3. Education will be provided to the Resident Services Director regarding the annual report requirements of the AWSAM annual report for submission to the Board of Nursing by July 1st each year as per guidelines. 4. An audit of the annual AWSAM report will be conducted at the beginning of each July, by the NHA or designee, to ensure timely submission has been completed. Corrective action will be taken as warranted. 2/29/12

Provider's Signature Mendy L. Nead, NHA Title Executive Director Date 2/6/12

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	A1 (AWSAM staff member): 4/13/2011 A2 (AWSAM staff member): 4/13/2011 A3 (AWSAM staff member): 4/6/2011 A4 (AWSAM staff member): 4/6/2011 A5 (AWSAM staff member): 3/11/2011 A6 (AWSAM staff member): 3/11/2011 A7 (AWSAM staff member): 1/12/2011 However the facility failed to submit an annual report of the above referenced AWSAM staff members to the Board of Nursing prior to August 1, 2011as required by the Delaware Nurse Practice Act, 24 Del.C. Ch. 19. These findings were reviewed with E1 (facility administrator) and E2 (regional RN) on 1/19/2012.	1. Resident #2 no longer resides in this Assisted Living facility. 2. All residents at risk for falls have the potential to be affected. All residents determined to be at risk for falls will have their service plans audited to ensure appropriate goals and interventions have been implemented. 3. The RSD will be provided education on the facility's Fall Risk Assessment policy and the need for implementation of appropriate interventions and goals for fall management. Falls will be reviewed within 24-48 hours after the incident by the RN and revision will be made to the service plan as needed. Residents with multiple falls will be reviewed in the facility's bimonthly risk meeting to ensure appropriate interventions have been implemented and that the service plan has been revised to meet the resident's needs. 4. A random audit of resident service plans will be completed by the NHA/Designee on residents identified as fall risk x 3 months to ensure compliance. Findings will be reviewed with immediate correction action as warranted. 2/29/12
3225.13.0 3225.13.5	**Service Agreements** **The service agreement shall be developed and followed for each resident consistent with that person's unique physical and psychosocial needs with recognition of his/her capabilities and preferences.** **This requirement is not met as evidenced by:** Based on clinical record review and staff interviews it was determined that the facility developed a service agreement that failed to include measurable goals and specific interventions that addressed fall risk and actual falls sustained by one resident (Resident #2) out of two sampled. Findings include: Clinical record review revealed Resident #2 had diagnoses that included Parkinson's disease, Parkinson's disease dementia, hypertension, depression and	

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	chronic renal failure. Review of the annual UAI dated 8/13/2011 revealed that Resident #2 was alert and oriented to time, place and person. Additionally the UAI assessment dated 8/13/2011 revealed that Resident #2 was at risk for falls due to the factors of a gait problem, impaired balance, confusion "on occasion", Parkinsonism, unstable transition from seated to standing position and "occasional" balance problems when standing. Further review of the clinical record revealed that "Fall Risk Assessments" were completed for Resident #2 on 2/13/2011 and 8/13/2011. Each of the above assessments revealed a score greater than 10 which indicated Resident #2 was at high risk for falling. The "Fall Risk Assessment" form also included instructions that stated "if the total score is 10 or greater, the resident should be considered at HIGH RISK for potential falls. A prevention protocol should be initiated immediately and documented on the care plan." Review of the clinical record also indicated that Resident #2 sustained approximately six falls between 8/17/2011 and 8/31/2011, four falls between 9/3/2011 and 9/28/2011 and four falls between 10/1/2011 and 10/23/2011. However review of the annual service agreement dated 8/13/2011 revealed that the facility failed to establish goals and failed to develop interventions that addressed the potential for falls. Additionally the facility failed to develop, evaluate, re-evaluate and implement measurable goals and specific interventions that addressed multiple falls sustained by Resident #2 between 8/17/2011 and 10/23/2011. These findings were reviewed with E1	

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	(facility administrator) and E2 (regional RN) on 1/19/2012.	